Case record

Submitted to the Dr M G R Medical University in partial fulfillment of the requirement for the **Diploma in Psychological Medicine** examination 2010

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Certificate

This is to certify that this case record is a bonafide record of work done by **Dr Arun R** (TN Medical Council Regn. No. 82842) and, submitted in partial fulfilment of the requirements for the award of the degree of **Diploma in Psychological Medicine**, during the academic period 2008-2010. I also certify that the record is an independent work by the candidate under my supervision.

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I express my sincere thanks to all the patients, who had co-operated for the assessments.

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CASE RECORD 1

Name	: Master V
Age	: 12 years
Sex	: Male
Religion	: Hindu
Language	: Tamil
Education	: 7th standard
Socio-economic status	: Low
Residence	: Rural
Informant	: Mater V and his mother

Presenting complaints

Hiccough	- one year duration
Preoccupation	- six months duration
Feeling sad	- six months duration
Crying spells	- six months duration

History of presenting illness

Master V was noticed to have persistent, intractable hiccough for the past one year. It was present throughout the day and was absent during sleep. He could voluntarily control the hiccough for only a while by holding his breath. The hiccough was exacerbated by anxiety-provoking situations. There

was no history suggestive of organic pathology for hiccough. Several physicians were consulted for the same but without any improvement.

For the past six months, Master V was observed to be preoccupied. He was found to be in tearful most often. He expressed that he felt sad but could not explain the reason. He was found to be disinterested in mingling with his peers. He was occasionally expressing feelings of helplessness. He also expressed guilt feelings. He reported that he had poor appetite. There was no change in his sleep pattern. He was able to maintain his basic activities of daily living.

There was no history of expressing hopelessness or worthlessness or suicidal ideas. There were no melancholic features. There was no history suggestive of hypomania or mania. There was no history of psychosis. There was no history suggestive of an organic involvement.

Developmental history

The pregnancy was planned and the antenatal period was supervised and uneventful. Delivery was full term normal vaginal; with no birth asphyxia or neonatal seizure. Postnatal period was uneventful. The developmental milestones were reported to be normal.

Emotional development and temperament

He was reportedly a less active and withdrawn child. He had difficulty in adjusting to new situations. He preferred to follow a fixed routine and did

not show interest in novel experiences. He did not initiate interactions in interpersonal situations and was described as being timid.

Sexual development

He had male gender identity and heterosexual orientation.

School history

His academic performance was reportedly below average, however there has been no failure. He is reportedly regular to school. Frequent school changes have not been present. He showed fearfulness towards his teachers and had limited interaction with them. There was lack of organization in his school work.

Personal History

He preferred the company of children of the same age however interaction was limited. He had few close friends. He was religious and followed social norms. There was no history of substance use or any other risk taking behaviors. There was no traumatic life events reported.

Family background

The parents were from a low socioeconomic background. There were financial difficulties in the family. He had an elder sister, studying in 9^{th} standard whose academic performance was better than his. His father

consumed alcohol frequently and his substance use behaviors led onto frequent problems between his parents. There was no history of any other neuropsychiatric disorder in the family.

Physical exmaination

Master V was small built for his age and gender (weight: 28 Kg; height: 130 cm). His vitals were stable. There was no evidence of nutritional deficiency. Systemic examinations were within normal limits. There was persistent hiccough.

Mental status examination

He was small built and adequately kempt. He was co-operative and rapport was established. Eye contact could be maintained. There was no restlessness and his activity level was found to be low. There were no abnormal involuntary movements. His primary mental functions were normal. Attention and concentration could be aroused and sustained. He had good immediate, recent and remote memory. He was oriented to time, place and person.

His speech was of low tone, monotonous and with a prolonged reaction time. There were no features suggestive of a formal thought disorder. There were no delusions or obsessive compulsions however depressive cognitions were present. His abstract thinking was concrete. He denied having any perceptual abnormalities. He had a depressed mood; affect was restricted with poor range

and reactivity, and was appropriate to thought process. He did not report suicidal ideation. Clinically his intelligence appeared average however needed further evaluation. He had grade 2 insight into the illness. His personal judgment was impaired; social and test judgments were normal.

Provisional diagnosis

MODERATE DEPRESSION WITHOUT SOMATIC SYNDROME

HICCOUGH FOR EVALUATION

Aim for psychometry

1. To clarify symptomatology, psychopathology and diagnosis
2. To identify conflicts that will help in psychosocial intervention

Tests administered

1. Bender Visual Motor Gestalt test
2. Child personality questionnaire
3. Thematic Apperception Test
4. Draw a person test
5. Kinetic family drawing test
6. Vineland Social Maturity Scale
7. Binet – Kamat Test

Rationale for the tests

Bender Visual Motor Gestalt test is a psychological assessment instrument used to evaluate visual-motor functioning and visual perception skills in both children and adults. It is used to evaluate visual maturity, visual motor integration skills, style of responding, reaction to frustration, ability to correct mistakes, planning and organizational skills and motivation. The test was also used to introduce the child to the testing situation.

Children's Personality Questionnaire is an objective personality test for children developed by Porter and Cattell in 1972 .It assesses personality factors under 14 dimensions and gives the personality profile of an individual.

Thematic Apperception Test is a projective measure intended to evaluate a person's patterns of thought, attitudes, observational capacity, and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes toward the self and others.

Draw-a-Person Test is a projective test to indicate personality and person's psychopathology.

Kinetic family drawing test is a projective test that requires the subject to draw a picture of his or her entire family. The subject is asked to draw a picture of their family, including themselves, "doing something." This

picture is meant to elicit the child's attitudes toward his family and the overall family dynamics.

Vineland's Social Maturity Scale measures social competence, self-help skills, and adaptive behavior from infancy to adulthood. It can be used from birth up to the age of 30, consists of a 117-item interview with a parent or other primary caregiver. Personal and social skills are evaluated in the following areas: daily living skills (general self-help, eating, dressing); communication (listening, speaking, writing); motor skills (fine and gross, including locomotion); socialization (interpersonal relationships, play and leisure, and coping skills); occupational skills; and self-direction. Raw scores are converted to an age equivalent score (expressed as social age) and a social quotient.

Binet – Kamat test assess the intelligence of the subject. It includes both verbal and performance tests. It can be administered to subjects aged 3 to 22 years.

Test findings

During the initial assessment sessions he was found to be anxious however became more comfortable as the testing proceeded. He was cooperative for testing and his comprehension of test instructions was fair. He

was fairly attentive and could persist on the task. IQ assessment was done once he was euthymic.

Bender Visual Motor Gestalt test

He had adequate fine motor functions. He could organize the figures well within the space provided. His visuomotor and visuoperceptual skills were fair. His immediate memory was inadequate and he could recall only 4 of the 9 figures. There were no features suggestive of organicity.

Children's Personality Questionnaire

His responses on the CPQ showed him to be a person who was reserved and detached. He was one who would be easily affected by feelings, emotionally less stable and sensitive. He had phlegmatic temperament was shy, restrained, diffident and timid. He was also sentimental. He was also found to be less intelligent.

Thematic Apperception Test

Most of his stories revolved around the fear of abandonment and feelings of insecurity. There was a need for approval and acceptance .He appeared to have a bleak view of his past as well as his current situation. Baseline anxiety and indecisiveness was also depicted in his stories. The desire to have a loving father was projected. He considered the environment as threatening and did not have the resources to challenge them. Most of the stories did not have a favorable ending.

Draw-a-Person Test

Both figures were proportionately small in size. There was also omission of body parts viz. only four fingers were drawn in each hand. The drawings were immature which may be indicative of lowered cognitive ability. The profile indicated feelings of anxiety and low self esteem. His verbalizations on the drawings reflected concern about academic performance and the need to excel. There appeared to be strong negative feelings towards his sister which was indicated in his drawings of the opposite gender.

Kinetic family drawing test

The pictures were primitive. The drawings depicted his desire to settle the problems between his parents. His ambition to perform better in examinations was also revealed. Strong resentment towards his sister was also revealed in his verbalizations about the drawing.

Vineland's Social Maturity Scale

He had an aggregate score of 82. His age equivalent score was 11.25, while his chronologic age was 12 years 1 month. He had scored in the normal range in the self-help categories. However his performance in communication and socialization was slightly low.

Binet – Kamat test

He had low average intelligence as indicated by an IQ of 86. His verbal ability was fair and numerical reasoning was fair. Visuomotor planning

was inadequate. His ability to read in English was poor however he was relatively better in Tamil which was his native language.

Conclusion and Management

The diagnosis of depression was confirmed. He was started on antidepressant. A diagnosis of Somatoform autonomic dysfunction (upper gastrointestinal) was also made. Principles of cutting down secondary gains and differential reinforcement were discussed.

He was found to be anxious, timid and less assertive. He had low average intelligence. There was pressure to excel in academics. Moreover there was comparison to a well-performing elder sister. This conflict resulted in strong resentment towards his sister. There was also a conflict due to low socioeconomic status. The boy was deeply distressed regarding the marital problems between parents and the substance use pattern of his father.

The implication of low intelligence on academic performance was discussed. A step down in curriculam with reduced pressure in academics was encouraged. Coping skill training, assertiveness training, academic skill building, role plays, group activities, and relaxation technique training were practiced. The need to avoid direct confrontation between parents in presence of children was stressed. The option of father getting treated for alcohol consumption in adult psychiatry too was discussed.

At the time of discharge, Master V was euthymic. There was marked improvement in hiccough.

CASE RECORD 2

Name	: Mr HK
Age	: 37 years
Sex	: Male
Marital status	: Married
Religion	: Hindu
Language	: Tamil
Education	: BCom incomplete
Occupation	: Business
Socio-economic status	: Middle
Residence	: Urban
Informant	: Mr HK and his wife

Presenting complaints

Repetitive intrusive thoughts	- twenty two years duration
Repetitive acts	- seventeen years duration

History of presenting illness

The complaints started while he was doing his intermediate. He started experiencing repeatitive and recurrent thoughts of dead body whenever he came across his close relatives, of throwing chappal at idol while worshipping and of faecal matter while taking food. He acknowledged those thoughts as

his own. He also considered those thoughts were absurd and senseless. But the thoughts were occurring without his will. They were so intrusive that his attempts to resist them most often failed. These thoughts were reportedly occurring in clear consciousness and, was dominating and persisting without any cause. Hence he was in deep distress. He could manage his studies and passed intermediate.

While doing BCom the intensity and severity of unusual thoughts increased. Moreover, he started having a repetitive and recurrent urge to keep things in order, check lock and zip. This also he considered as own action not being imposed by others, as absurd and senseless, but intrusive occurring in clear consciousness. These were dominating and persisting without any cause. There was release of tension after the act.

The thoughts and acts were so intense that he sometimes used to feel death wish. His sleep too was disturbed. There were no active suicidal plans or suicidal attempts so far. There was no pervasive sad mood or lack of interest in pleasurable activities or easy fatiguability. There was no pervasive feeling of worthlessness or hopelessness or helplessness. There was no loss of libido or loss of weight. There was no early morning awakening.

The thoughts and acts were so impairing that he stopped his studies. He could not make steady progress in business so that he was expelled by his business partners. Though his personal care was reportedly adequate, there was severe interference due to the complaints. There was impairment in instrumental activities of daily living.

There was no history suggestive of first rank symptoms.

There was no history of expressing false belief with conviction.

There was no history of any abnormal perception.

There was no history of mania or hypomania.

There was no history of phobia or panic attacks.

There was no history suggestive of organicity or seizures.

Treatment history

The details of treatment history were incomplete. He reportedly contacted a Psychiatrist over phone and took some medication, a few months after onset of symptoms. There were no improvements. Later, when he started expressing death wish, he was hospitalized and was given electroconvulsive therapy. No major improvement was reported with that too. Currently, he was on Lamotrigine, Escitalopram, Fluvoxamine, Propanolol and Clomipramine.

Family history

He was strong family history of obsessive compulsive disorder. His mother, maternal grandmother and maternal uncles and aunts were diagnosed of obsessive compulsive disorder. The treatment details were not available. Maternal grandmother had reportedly committed suicide, the reason for which is not known.

Developmental history

The antenatal period was supervised and uneventful. Delivery was full term normal vaginal; with no birth asphyxia or neonatal seizure. Postnatal period was uneventful. The developmental milestones were reported to be normal.

Educational history

Upto intermediate education he was reportedly average in studies. From BCom, his academic performance deteriorated primarily due to the illness and he stopped his studies. He was reportedly friendly towards peers and teachers. He was active in extracurricular activities.

Occupational history

He was doing garment business on partnership. But the illness had become so interfering that he was expelled from partnership.

Sexual development

He had male gender identity. He reported heterosexual orientation. There was no masturbatory guilt. He denied any high risk sexual behaviour.

Marital history

He was married to Mrs D, who is a housewife. Their marital life and sexual life were reportedly unsatisfactory because of his illness affecting the overall quality of life. Sexual dysfunction needs to be probed later.

Premorbid personality

He had alcohol use from 2007 but not in dependence pattern. He cited the distress of illness as the reason for substance use.

Physical examination

His vitals were stable. Systemic examinations were within normal limits. There were no self-harm marks.

Mental status examination

He was well built and kempt. Eye contact could be maintained. He had a tense facial expression. Rapport was easy to be established. There was no restlessness. His level of activity was normal. There were no abnormal involuntary movements. He was co-operative. His primary mental functions were normal. Attention and concentration could be aroused and was sustained. He had good immediate, recent and remote memory. He was oriented to time, place and person.

His speech was of normal tone, pitch, reaction time, speed.

Form and stream of thought were normal. Content of thought revealed repeatitive, intrusive, absurd and senseless thoughts, which he considered as hisown but unable to resist. It was happening in clear consciousness. There was severe distress about the thoughts. No delusions or depressive ideas were elicited. There was no thought broadcast or thought control or thought insertion. There were no perceptual abnormalities. Subjectively, he expressed sad mood. He denied any suicidal ideas. There were compulsions of symmetry and handwashing. . He considered his problems to be part of psychiatric illness and volunteered for treatment indicating good insight. His personal judgement was impaired. His social and test judgements were intact.

Provisional diagnosis

OBSESSIVE COMPULSIVE DISORDER – MIXED

Aim for personality assessment

To assess baseline personality and to understand more on psychopathology

Tests administered

1. Thematic Apperception Test
2. 16 PF Questionnaire
3. Sacks Sentence Completion Test

During the entire exercise, he was cooperative. He could comprehend the instructions and paid adequate attention. He appeared well motivated. He was keen on understanding the tests in detail and was probing repeatedly.

Rationale and Findings

Thematic Apperception Test is a projective measure intended to evaluate a person's patterns of thought, attitudes, observational capacity, and emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes toward the self and others.

Test findings

On TAT analysis his main themes were about an individual who was helpless initially, but achieves great things later, becomes famous and helps others. His main needs were need for secureness, sex, achievement & affiliation. His natures of anxieties were deprivation, helplessness, being overpowered. The significant conflicts were sex vs. morality, support vs. independence, affiliation vs. rejection, autonomy vs. compliance, helpless vs. autonomy. The main defense mechanisms that were used were altruism, reaction formation, projection and sublimation. Most of the stories has a happy outcome and were realistic.

16 PF questionnaire measures a set of 16 traits that describe and predict a person's behaviour in a variety of contexts. It aims to provide comprehensive information about an individual's whole personality, revealing potential, confirming capacity to sustain performance in a larger role and

helping identify development needs. It is an empirically based tool that helps to remove the subjectivity inherent in the interview or assessment process

Test findings

He has scored high on factor C and Q3 indicating high ego strength and obsessive compulsity. High score of E and Q1 also indicates hostility in covert ways rather than through confrontation. High Q1 also indicates difficulty with authority figures. The parental identification or introjected ego ideal is refelected in low L score. He seems to be a less sophisticated and manipulated person with a poor deal of experience in social relations. Low Q2 also points to less self-sufficiency and productive life style. Major area of his vulnerability lies in the direction of psychosomatic symptoms. This is inferred because of his slow score on I (emotional sensitivity) and M (imagination) which suggests that he is vulnerable to develop somatic symptoms under stress. Low M implies poor practical approach to life. These psychosomatic symptoms can also serve as an outlet for secondary gains.

Sacks Sentence Completion Test is a projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

Test findings

On SSCT protocol patient revealed significant conflicts and disturbances in the domain of family especially with parents, guilt associated

with masturabation and sex relations, negative attitude towards opposite gender and strong hatred towards mother.

Conclusion and Management

The defense mechanisms were mostly mature and neurotic. There were major conflicts in areas of sexuality and autonomy. Obsessive compulsive personality with ego strength was confirmed. He was found to be vulnerable to social rejection. There was also tendency to loss self-sufficiency. Both finally may culminate in somatisation with secondary gain. There were significant conflicts in family relations especially with parents. Hatred towards mother has to be explored. Conflicts in sexuality warrants further probing.

It was decided to give an adequate trial of Fluoxetine and augment it with Clonazepam. Non-pharmacologically, cognitive behaviour therapy too was started. It primarily involved exposure-response prevention strategy, where he was repeatedly exposed himself to provocative stimuli and refrained from compulsions. For this, a complete list of obsessions, compulsions, and things that he avoided was first made. This list was then arranged in a hierarchy from least anxiety-provoking to most anxiety-provoking. He then started with a moderately anxiety-provoking stimulus and repeatedly exposed himself to it until the situation produces minimal anxiety (i.e., habituation). The next (more anxiety-provoking) stimulus in the hierarchy was then tackled.

This was combined with cognitive therapy, in which faulty beliefs were challenged to help reduce the feeling of impending catastrophe.

Social skills training with focus on helping him to deal with heavy responsibilities and stress was also undertaken. Specific techniques as instruction, feedback, and reinforcement of positive interactions were used.

CASE RECORD 3

Name	: Mr. SKA
Age	: 25 years
Sex	: Male
Marital status	: Unmarried
Religion	: Hindu
Language	: Bengali
Education	: 12th standard incomplete
Occupation	: Currently unemployed
Socio-economic status	: Middle
Residence	: Rural
Informant	: Mr SKA and his father

Presenting complaints

Irritable and abusive	- ten year duration
Blaming parents	- ten year duration
Somatic preoccupation	- ten year duration
Impaired activities of daily living	- ten year duration

History of presenting illness

From early childhood onwards, Mr SKA was reported to be adamant. He had poor frustration tolerance that even for trivial incidents at school or at

home he will be angry and sometimes agitated. But significant changes were noticed since he was studying in 12th standard. Then he was found preoccupied with his physical appearance. He started complaining that there was more hair growth in him. He expressed concern that he was losing vitamins due to this. Hence he used to apply costly cosmetics, for which he always quarreled with his father. Once he found that cosmetics were not reducing his hair growth he started demanding consultations at various cosmetologists. He was also concerned about asymmetry of his jaw bone. Since there was no improvement with expert consultation he started demanding LASER therapy for the same.

Almost during the same period, he used to get angry even for other reasons like not serving him tea on time. It was also reported that he would not persist with a task that yielded no immediate reward. He insisted on that he would do things on his own way and would not agree to others' suggestion. At the same time he will deeply be moved by criticism.

He tends to blame others when criticised. He used to blame parents for all his failures. He was always found complaining to others that he was not brought up well; he was not guided properly by parents; he was not made to excel in his academics. He used to be abusive and assaultive towards parents. He was also found blaming his friends for inappropriate behaviour toward him. He also pointed fingers at school authorities for lack of infrastructure at school, one of the reasons he considered for his poor scholastic performance.

His sleep too was disturbed. There was difficulty in sleep initiation. He used to get up late in the morning. His personal care was reportedly adequate, but there was no routine. Since all these complaints started simultaneously while studying in 12^{th} standard, he did not complete the academic year. Then he worked in a stationary shop. Gradually he stopped going for work. Thereafter he spent all his time at house mostly sleeping or relaxing. There was gross impairment of instrumental activities of daily living.

There was no history suggestive of first rank symptoms.

There was no history of expressing false belief with conviction.

There was no history of any abnormal perception.

There was no history of depressive syndrome or mania or hypomania.

There was no history of phobia or panic attacks.

There was no history suggestive of organicity or seizures.

His index visit to us was on 25/4/2007 with multiple somatic symptoms, anxiety and agitation. Initially, possibilities of anxious personality disorder and somatoform disorder were considered. Later on, he was described to have repeated behaviour of checking and washing. Hence, diagnoses of Obsessive compulsive disorder and Somatisation disorder were made.

Treatment history

He was on Fluoxetine 60 mg/day and reported substantial improvement of compulsions. Low dose Risperidone was later added to control his aggression. He was off medication for the past one and a half years.

Family history

He was the youngest of five siblings. There was no neuropsychiatric morbidity in family. His father was reported to be anxious and short-tempered. He was described to be authoritarian in parenting.

Developmental history

The antenatal period was supervised and uneventful. Delivery was full term normal vaginal; with no birth asphyxia or neonatal seizure. Postnatal period was uneventful. The developmental milestones were reported to be normal.

Educational history

He was studying in 12^{th} standard when he stopped going to college. His academic performance was reportedly average. He had limited interaction with his peers and teachers.

Sexual development

He had male gender identity and heterosexual orientation. There was no masturbatory guilt. He denied any high risk sexual behaviour.

Marital history

He was unmarried

Premorbid personality

He had limited social interaction. He was reportedly irresponsible towards work. He had poor moral standards. He was reported to be anxious. He had alcohol use and smoking, not in dependence pattern

Physical examination

His vitals were stable. Systemic examinations were within normal limits. There was mild asymmetry of angles of mandible.

Mental status examination

He was moderately built. He was well kempt. He was overcautious about his physical appearance. Eye contact could be maintained. Rapport was difficult to be established. There was no restlessness. His level of activity was normal. There were no abnormal involuntary movements. He was co-operative. His primary mental functions were normal. Attention and

concentration could be aroused and was sustained. He had good immediate, recent and remote memory. He was oriented to time, place and person.

His speech was of normal tone, pitch, reaction time and speed. Form and stream of thought were normal. Content of thought revealed persistent preoccupation with his self-image, physical appearance and resentment towards parents. There was over-concern about his physical appearance viz. asymmetry of mandible and overgrown facial hair. The beliefs were strongly held but could be challenged. No delusions or depressive ideas were elicited. There was no thought broadcast or thought control or thought insertion. There were no perceptual abnormalities. Subjectively, he expressed sad mood due his problems and uncertainty about his future. He denied any suicidal ideas. There were no obsessions or compulsions. He considered his problems to be the result of poor parenting and wanted them to change indicating poor insight. His personal judgement was impaired.

Provisional diagnosis

MIXED PERSONALITY DISORDER

PRODROME OF PSYCHOSIS

Aim for psychometry

To clarify symptomatology, psychopathology and diagnosis

Tests administered

1. Rorshach test
2. Thematic Apperception Test
3. Sacks Sentence Completion Test

Behavioural observation

During the entire exercise, he was cooperative. He could comprehend the instructions and paid adequate attention. He appeared well motivated.

Rationale and Findings

Rorshach Ink Blot Test provides an understanding of structure of the personality, affectional needs and ego strength. It also indicates degree of psychopathology.

Test findings

On the protocol he had given > 14 responses indicating that quantitative analysis could be carried out. The Lambda score was high indicating that he has an avoidant style. Most of the responses were anatomical responses. He is chronically vulnerable to become more disorganised when there are stressors in life. Low adj D score indicates that the impact of stress creates considerable unacceptable patterns of thinking or behaviour. Higher EB score indicates that he has an 'avoidant-extratensive style' indicating that he is more prone to be influenced by emotional stimuli and uses emotions effectively in decision making. Potentially there is serious lapse in modulation of emotions.

There is significant meditational impairment. Reality testing is impaired and a psychotic-like process exists. Most of the responses represent distortion of reality. Less number of popular responses indicates the tendency to disregard social conventions in favour of individual needs or wants. More number of anatomical responses indicates severe impairment in reality testing and somatic preoccupation. There is increased tendency to think inflexibly and he has difficulty in attempting to think with alternative views. He has frequently distorted notions about himself. He has limited self-awareness and is very negative in decision-making and problem-solving capacity. He may be striving to accomplish more than may be reasonable in light of current functional capabilities. If this tendency occurs in everyday behaviours, the probability of failures is increased which may lead to frustrations. There is no cause of concern about the effectiveness of his mediational process however; he tends to make decisions that disregard social demands or expectations than do most people.

High Dd responses and less popular responses indicate an obsessive-like tendency toward perfectionism. He is more preoccupied by minute details of the stimulus field. On the special index of obsessive style, patient's protocol meets its criteria indicating that he has an obsessive approach to situations.

Thematic Apperception Test is a projective measure intended to evaluate a person's patterns of thought, attitudes, observational capacity, and

emotional responses to ambiguous test materials. It elicits information about a person's view of the world and his attitudes toward the self and others.

Test findings

On the TAT protocol, most of the stories were well structured. The recurrent themes were that of the hero facing difficulties in life and then actively fighting back the pressure. Mostly female heroes have been identified whose prominent needs were need for secureness and affliation. The environment in most of the stories has been perceived as threatening and unsupportive. The significant conflicts that surfaced were secureness versus rejection. The main anxieties were that of deprivation and of being overpowered and helpless. The main defenses used by the hero were projection and reaction formation. Superego structure was found to be adequate. Overall in the TAT stories, the integration of ego was found to be inadequate. However the outcome in most stories was realistic and happy.

Sacks Sentence Completion Test is a projective test developed by Dr Sacks and Dr Levy. It consists of 60 partially completed sentence to which respondent adds endings. The respondent projects the attitudes towards a personal experience of life. It helps to elicit ideas of self-perception.

Test findings

On SSCT the person has main difficulty in interpersonal areas such as with parents and stressful home environment. He also revealed significant conflicts and disturbances in the domain of family particularly with parents' marital relationship, future, fears and guilt feeling regarding past.

Conclusion

The tests revealed his personality traits viz. avoidant, emotional dysregulation, sensitivity to stressors, and obsessions. He was prone to exhibit maladaptive behaviour under stressful situation. His disregard to social norms was also evident. The difficulty in decision-making and problem-solving justify his dissatisfaction with life. The environment was perceived threatening and insecure. Poor interpersonal relations can be due to both the cause and the effect of his psychopathology. The test results also point towards his significant difficulty in reality testing indicating a psychotic psychopathology. The use of narcissistic and neurotic defenses further strengthens the possibility of psychosis and personality disorder respectively. A current working diagnosis of mixed personality disorder with high index of suspicion of prodrome of schizophrenia was concluded.

Management

Patient`s father and patient were psychoeducated. Rapport was estabilished. Supportive psychotherapy was employed to expand personal abilities and skills. The need for cognitive behavioural approach for correcting negative automatic thoughts was discussed. The importance of addressing unlovable core beliefs was emphasised. Behavioural strategy with differential reinforcement of skill and maladaptive behaviour was discussed. Structured schedule was discussed and developed. Problem-solving skills training were initiated with the help of occupational therapy department.

Mr SKA's father was allowed to ventilate. The implications of test findings were discussed. He was asked to be consistent in his response contingent with adaptive behaviour and, not budge to pressure. The early warning signs of schizophrenia were discussed.

Mr SKA was continued on Fluoxetine in view of past good response of compulsions. Low dose antipsychotic, Risperidone, was started in view of high risk of schizophrenia and, because of its observed benefit in control of aggression. He was discharged because of his personal inconvenience. He was asked to get admitted on a later date for employing non-pharmacological interventions. His father has been advised to bring him early, if there were any early warning signs of schizophrenia.

CASE RECORD 4

Name	: Mr ARS
Age	: 34 years
Sex	: Male
Marital status	: Unmarried
Religion	: Hindu
Language	: Tamil
Education	: ITI
Occupation	: Electronic mechanic
Socio-economic status	: Low
Residence	: Rural
Informant	: Mr ARS and his parents

Presenting complaints

Recurrent episodes of complex motor activities of right hand

- since twelve years of age

Mode of onset - abrupt

History of presenting illness

The episodes started when Mr ARS was twelve years of age. Mr ARS's mother first noticed that, Mr ARS had a vacant stare while having his lunch. She also observed that he was spreading the food in plate with his right

hand. Suddenly she called him but he was found unresponsive. After twenty to thirty seconds, he became responsive. There was no major confused state after the episode. When his mother tried to clarify what was happening, he could not recollect whether any such episode has happened. There was no involvement of any other limbs. There was no lip smacking or any other complex motor activity. There was no aura. There were no tonic-clonic movements or incontinence or frothing or loss of consciousness with postural fall suggestive of generalised tonic-clonic seizure. There was no fever prior to the episode. Afterwards, he was normal to his studies with no residual effect. Hence he was not consulted then.

Four months later he had second episode of similar semiology. Then he was taken to a local physician who started him on Carbamazepine. While on medication, he again had similar episode four months later. Then he was consulted by a Neurologist. After imaging, the dose of Carbamazepine was titrated. But he continued to experience at least one episode every four months mostly while having food. The episodes were not interfering with his daily activities and the episodes were of short duration that they did not seek any change in medication. He was compliant with medication but no drug levels were done.

From the age of twenty nine, he started experiencing aura – an abnormal sensation in abdomen that ascends upto his neck and a sense of arrested speech. This will last a few seconds. It will be followed by the

episode as described before. It was reported that not all aura was followed by seizure.

During the same period, while driving a motorbike he probably had an episode; he fell down; he sustained left clavicular fracture. A few other episodes occurred at work place. While he was soldering he developed a seizure episode. Then he unknowingly moved the soldering iron to his face and burned his face. Similarly he burned his hand once.

Since the episodes started affecting his daily activities some of which were life threatening, he consulted another Neurologist. He was started on Phenytoin in addition to Carbamazepine. The dose was titrated. There was no significant change in frequency or severity of episodes. In view of poor response to two antiepileptic medications, Sodium valproate was added as third antiepileptic. Even then he continued to have seizure in the same frequency.

Hence he was brought to CMC for expert opinion. Drug levels were found to be within normal range indication good drug compliance. In view of poor control of seizure with three antiepileptics with good compliance, option of surgery was discussed. Meantime it was decided to try fourth antipepileptic Clobazam and, to taper off Carbamazepine and Sodium valproate. But he continued to develop seizure. Moreover, he could not tolerate the dose of Phenytoin that was prescribed. He had severe side effects and hence he stopped the medicine.

There was no history of apathy or emotional lability or sexual disinhibition.

There was no history of forgetfulness or difficulty in speech.

There was no history of apraxia or difficulty in calculation.

There was no history suggestive of psychosis or syndromal depression or mania.

There was no history of deviant personality traits or obsessions or compulsions or phobia or panic attacks.

There was no history of head injury.

His biological functions were reportedly normal. He still continued to maintain his basic and instrumental activities of daily living independently.

Past history

At the age of two and a half years he had one episode of tonic posturing of all four limbs with uprolling of eyes. It happened on the first day of febrile illness. It lasted nearly one minute. Thereafter he was unresponsive for nearly 15 minutes. He was provided local treatment; no further evaluation was done. He was not started on any regular antiepileptic medication. But, during the onset of febrile illness they were instructed to give him antipeileptics till fever subsides. There was no past history of any other neuropsychiatric morbidity or any other medical illness.

Family history

There was no known relevant neuropsychiatric morbidity in his family.

Birth and development history

He was born to non-consanguineous union in May 1975. The antenatal period and was uneventful. The birth was at full term by Caesarean section, the indication being previous Casarean section in mother. There was no birth asphyxia. Birth weight was 2.25 Kg. He was started on breastfeeding soon after birth. The developmental milestones were reported to be normal.

Educational history

He has studied upto ITI in Television mechanics. He was described to be average in academics. His relationship with his peers and his teachers was warm.

Occupational history

He was working as Television mechanic for the past ten years. He was regular to work. There were a few episodes of work-related injuries due to him developing episodes while working.

Sexual history

He had heterosexual orientation. He denied any premarital high risk sexual behaviour.

Marital history

He is unmarried.

Premorbid personality

He was described to be a sociable and hardworking person. He was religious and responsible towards work and his family. He was interested in watching television. There was no history of any substance use.

Physical examination

His vitals were stable. There was no pallor or lymphadenopathy. There was no gingival hypertrophy. His cardiovascular system examination, respiratory system examination and gastrointestinal system examinations were normal.

Central nervous system

Higher function – MMSE 30/30

Cranial nerves – No cranial nerve palsies

Motor system

Bulk - Normal bilaterally

Tone - Normal tone bilaterally

Power - Grade 5 power bilaterally

No involuntary movements

Sensory system

Crude touch, Pain, Temperature - Normal bilaterally

Light touch, Vibration and Joint position sense - Normal bilaterally

Reflexes

Superficial abdominal reflex - Present all four quadrants

Plantar reflex - Flexor bilaterally

Deep tendon reflexes - 2+ bilaterally

Cerebellar functions - No signs of cerebellar dysfunction

Gait - Normal

Meningeal signs - Absent

Skull and spine - Normal

Mental status examination

He was moderately built and nourished, and was adequately kempt. Eye contact could be maintained. Rapport was established. There were no restlessness or overactivity or abnormal involuntary movements. His primary mental functions were normal. Attention and concentration could be aroused easily and was sustained. He had good immediate, recent and remote memory. He was oriented to time, place and person. Speech was audible with no deviation.

There was no formal thought disorder. There were no depressive cognitions. But he expressed his distress associated with uncontrolled episodes. There were no delusions. There were no obsessions and

compulsions. His abstract thinking was normal. He denied having any perceptual abnormalities. There were no predominant mood symptoms. He did not report of any suicidal ideation. His intelligence was average. He had grade 5 insight into illness. His personal, social and test judgements were normal.

Provisional diagnosis

COMPLEX PARTIAL SEIZURE – poor response to medications

Past history of febrile seizure

Aims for neuropsychological testing

1. To find out the cognitive profile of Mr ARS
3. To relate the findings to clinical presentation
4. To identify the neuroanatomical and neurophysiological sites of lesion
5. To have a baseline cognitive functioning prior to surgical options

Tests administered

1. Mini-mental state examination
2. NIMHANS Neuropsychological Battery

Rationale and findings

Mini-mental state examination – Introduced by Folstein in 1975. It is being introduced as a screening for gross cognitive impairment. It can help to

confirm diagnosis, assess the severity and, monitor the progress and outcome of treatment. MMSE measures orientation, attention and calculation, immediate and short-term recall, language, and ability to accomplish simple verbal and written instruction as well as visual construction. The total score is 30.

Test findings

The MMSE score was 30 indicating intact orientation, attention and calculation, immediate and short-term recall and language. The ability to accomplish simple verbal and written instruction as well as visual construction too were normal.

NIMHANS Neuropsychological Battery – Developed by Dr C R Mukundan. This tests a subject's performance across lobe functions. It has been validated to suit the Indian adult population. It comprises of a series of tests that test the following functions

Frontal lobe: Attention, scanning, ideational fluency, abstraction, delayed response learning, execution of motor tasks

Parietal lobe: Perceptual (Bender visual motor Gestalt test), visual analysis and synthesis (Block design test), test for spatial relations and tests for parietal lobe focal signs

Temporal lobe: Sentence repetition, comprehension, verbal learning and memory, visual integration (Object assembly test), visual memory (Benton's visual retention test) and visual learning and memory

Test findings

On NIMHANS Neuropsychological Battery, patient was alert during testing. He was motivated and cooperative. He was able to comprehend test instructions adequately.

His attention could be aroused and sustained for a prolonged period. His performance on tests of scanning and trail making was adequate. He performed adequately on execution of motor tasks, kinetic melody, ideational fluency and working memory. There was no motor perseveration evident. His performance on expressive and receptive functions was adequate. His abstract ability was inadequate. He has performed inadequately on spatial perceptual functions and spatial relations evident on BGT (rotation, macrographia, overlapping, workover) and three dimensional drawings. He had adequate visuo-constructive skills. There was no evidence of agnosias, apraxias, body-schema disturbances or any other parietal focal signs. His comprehension, memory of simple sentences was adequate. He has adequate visual integration skills. His associate learning ability and verbal learning & memory was adequate. However, his visual learning and memory was severely impaired.

Conclusion

Neuropsychological assessment revealed right parietal – temporal involvement with mild deficits in prefrontal cortex. Spatial relations and visual learning and memory were found mostly affected. These findings correlates well the clinical presentation of complex partial seizure.

Management

Mr ARS and his parents were educated on the nature of illness and, about the assessment results. The distress was acknowledged and, supportive psychotherapy was employed to prevent emotional breakdown.

He was referred to Department of Neurology for evaluation of surgical option. He was advised to review after the procedure to assess the cognitive impact of neurosurgery.

CASE RECORD 5

Name : Mater T A

Age : 13 years 10 months

Sex : Male

Education : Standard IX

Informant : Parents

Reliability : Good

Presenting complaints

Disobedience and Poor academic performance

Duration of illness – since the age of 9 - 10 years

Mode of onset – Insidious

Precipitating factors – Nil

History of presenting complaints

Master T A was brought with history of disobedience, abusing parents, demanding immediate ratification of his demands, behaving opposite to what elders ask him to and deliberately annoying others, since he joined 5th standard. Simultaneously there was gradual deterioration in his scholastic performance. He was reportedly inattentive in class and was disturbing his classmates during sessions. Back at home, he was spending little time for his studies, often making excuses during study time. He could independently

carry out age-appropriate basic and instrumental activities of daily living. There was no history suggestive of attention deficit hyperactivity disorder or conduct disorder. There was no history suggestive of psychotic syndrome, mood syndrome, obsessive-compulsive disorder, anxiety disorder or phobia. There was no history suggestive of organicity or substance use.

Past history

There was no significant past medical history

Birth and development history

Prenatal: Planned pregnancy with nil significant history

Perinatal: Full term normal delivery at hospital with newborn weighing 2.95 Kg who cried soon after birth

Postnatal: Breast fed upto 2 years of age. Immunised for age.

Emotional development and temperament

He was described to be a difficult child – adamant, demanding and seeking immediate ratification of demands. He was reportedly throwing temper tantrums if his demands were not met. He abused parents on such occasions. He did not have self-injurious behaviours so far.

School history

He is studying in 9th standard. The medium of instruction is Bengali. He was reportedly scoring around 80 percent marks until 4th standard. He was also reportedly obedient with no behavioural problems or problems with peer group. After he joined 5th standard, every academic year his scholastic performance dropped. In 9th standard he scored 60 percent marks and was reportedly inattentive in classes. He also developed problems with peer group.

Family history

His father's cousin was epileptic and had committed suicide. His paternal aunt has Schizophrenia. There is no family history of mental retardation or conduct disorder or oppositional defiant disorder.

Physical examination

Master TA was overweight. His systemic examinations were within normal limits.

Mental status examination

He was overweight and was well kempt. He was co- operative and alert during interview. Primary mental functions were intact. Speech was normal in tone, rate and reaction time. Form, stream and content of thought were normal. He denied any perceptual abnormality. His mood was euthymic. His intelligence appeared compromised as suggested by impairment in tests of

abstraction and general knowledge. He had partial insight. His judgment was intact.

Provisional diagnosis

OPPOSITIONAL DEFIANT DISORDER

UNSPECIFIED MENTAL RETARDATION

Aims of psychological testing

As history was suggestive of poor scholastic performance and, mental status examination revealed impairment in tests of abstraction and general knowledge, IQ assessment was imperative.

Tests administered

1. Vineland Social Maturity Scale (VSMS)
2. Binet-Kamat Test

Rationale for the tests

1. VSMS was used to assess the social adaptation and social age
2. BKT was used to assess intelligence as it is standardised in the Indian population

Behavioural observations

Master T A was co-operative and willing for the tests. He was able to comprehend instructions. He was attentive and was able to persist on the task. No hyperactivity or anxiety was observed.

Test findings

1. **VSMS**

The social age of Master T A was 15.85 years, which was adequate for his age. The profile of age levels across the functions was as follows:

Self-help general	7.28 years
Self-help dressing	8.85 years
Self-help eating	9.03 years
Communication	14.95 years
Self-direction	16.53 years
Socialisation	12.30 years
Locomotion	15.85 years
Occupation	10.90 years

2. **Binet- Kamat Test**

Mental age – 12 years 4 months

Chronological age – 13 years 10 months

Function wise

Language 12 years

Meaningful memory	10 years
Non-meaningful memory	9 years
Conceptual thinking	14years
Non-verbal thinking	16 years
Verbal reasoning	years
Numerical reasoning	14years
Visuo-motor	10 years
Social intelligence	12 years

The IQ of Master T A was 89. On applying Flynn effect the IQ was 79, which indicated Borderline intelligence.

Impression

The tests revealed that Master T A had significant impairment in language, meaningful and non-meaningful memory, visuo-motor and social intelligence. The IQ according to the Binet- Kamat test was suggestive of Borderline intelligence.

Management

1. The parents were educated about his dual diagnosis and its implications. They were allowed to ventilate and support was provided. Their doubts were clarified.
2. For addressing oppositional defiant disorder, Mr T A and his parents

were taught the importance of maintaining Activities of Daily Living Chart and, following a token economy programme. The parents were also taught about Behavioural management techniques and differentially rewarding skill behaviour and problem behaviour.

3. The need for scaling down academic expectation in view of borderline intelligence was discussed with parents. It was discussed to inform the school authorities to avoid putting undue academic pressure. It was discussed to differentially reward Master T A for his attempts to study rather than on concentrating on outcome. The possibility of searching vocational training as an option following his completion of 10^{th} standard too was discussed.
4. The need for in-patient care in light of failure of behavioural strategy was discussed.